MO-2005-88

Mobile Police Department November 17, 2005

SUBJECT: RECOGNIZING AND HANDLING PERSONS WITH MENTAL ILLNESS

TO: All Personnel

PURPOSE: To enhance officers' ability to recognize, understand and deal with a person with mental illness

I. Response to People with Mental Illnesses

Information Provided to the Officer from the Dispatcher

The Communications Unit Dispatcher should provide as much relevant information to responding officers as possible to identify the nature and urgency of the situation as well as to identify prior involvements with the individual.

A. Dispatchers should specifically provide information on the presence of weapons, violent behavior and the nature of the problem. Officers should not assume that there are no weapons, even though there is a report of no weapons.

B. Dispatchers may also have information on prior involvements or calls, which can be beneficial for the officer. Such information may include past occurrences of calls due to mental illness; past incidents of injury; or past threats of harm to self or others.

Responding to an Emergency Call

When responding to an emergency call that involves a person who has or exhibits symptoms of mental illness, officers should obtain as much information as possible to assess and stabilize the situation. In particular, officers should gather information regarding the nature of the problem behavior, events that may have precipitated the person's behavior, and the presence of weapons. This information may come from the subject, their family members, neighbors, prior involvements, etc. As indicated above, even though a person reports that the individual has no weapons, the officer should not assume this to be correct until the officer confirms that the individual has no weapons.

Approaching and Interacting with a Person with Mental Illness

Officers should do the following:

A. Remain calm and avoid overreacting.
B. Remove distractions, upsetting influences and disruptive people from the scene.
C. Follow procedures indicated on medical alert bracelets or necklaces.
D. Be cognizant of medications that may indicate mental illness.
E. Indicate a willingness to understand and help.
F. Speak simply and briefly, and move slowly.
G. Understand that a rational discussion may not take place.
H. Recognize that the person may be overwhelmed by sensations, thoughts, frightening beliefs, sounds ("voices") or the environment.

I. Be helpful and professional.
J. Be friendly, patient, accepting and encouraging, but remain firm and professional.
K. Be aware that their uniform, gun, handcuffs and nightstick may frighten the person with mental illness, and reassure the person that no harm is intended.
L. Maintain a safe distance from the subject to afford reaction time.
M. Recognize that a person's delusional or hallucinatory experience is real to him/her.
N. Announce actions before initiating them.
O. Gather information from family or bystanders.
P. If the person is experiencing a psychiatric crisis, access available emergency medical/mental health resources.

Behaviors the Officers Should Avoid

Officers should not do the following:

A. Move suddenly, giving rapid orders or shouting.
B. Force discussion.
C. Maintain direct, continuous eye contact.
D. Touch the person (unless essential to safety).
E. Crowd the person or move into his or her zone of comfort.
F. Express anger, impatience or irritation.
G. Assume that a person who does not respond cannot hear.
H. Use inflammatory language, such as "crazy," "psycho," "mental" or "mental subject."
I. Challenge delusional or hallucinatory statements.
J. Mislead the person to believe that officers on the scene think or feel the way the person does.

Dangerous or Threatening Behavior

If the person is acting dangerously, but not directly threatening any other person or self, or is in a position that they cannot harm anyone, the person should be given time to calm down. Violent outbursts are usually of short duration. It is better that the officer spend 15 to 20 minutes waiting and talking than to spend five minutes struggling to subdue the person.

Medication Issues

Police officers should be aware that some medications that treat mental illness have side effects that may require attention. For example, medications may cause tremors, nausea, extreme lethargy, confusion, dry mouth, constipation or diarrhea. Police officers should attend to needs for water, food and access to toilet facilities. It is important not to mistake these side effects as evidence of alcohol or drug abuse. If the encounter lasts for some time, or a detention, interview or interrogation is being conducted, people with mental illnesses may need access to their medication. Officers must follow the law and departmental rules for verifying that any pills or capsules the person is carrying are prescribed, or to obtain the needed medication, so that they may authorize the individual to continue the prescribed treatment.

If the officer takes the individual into custody, whether for jail or hospitalization, the individual's medication should be given to the proper personnel at the facility. Do not give the medications to the individual.

Communication

Communication is essential to successful management. It allows the officer to gain valuable information regarding the problem. It also enables the officer and the subject to understand each other, and in turn, reduces the tension that accompanies these encounters.

Symptoms of Mental Illness

The following is a list of possible signs and symptoms of mental illness in an individual. This list should not be considered all-inclusive. It is important to recognize the possible signs or symptoms so that appropriate action can be taken.

A. Mood or Emotional Symptoms

1. Depressed mood
2. Elevated mood
3. Irritable mood
4. Anxious
5. Fear
6. Panic
7. Anger

B. Behavioral Symptoms

1. Changes in behavior/conduct/demeanor
2. Bizarre/Unusual behavior, appearance or mannerisms
3. Threatening, aggressive or hostile behavior
4. Violent and/or destructive actions
5. Suicidal or self injurious behavior
6. Increased Behavior/Activity (sleep, speech, appetite, sexual desire, etc.)
7. Decreased Behavior/Activity (sleep, speech, appetite, sexual desire, etc.)
8. Episodes of excessive spending
9. Reckless behavior
10. Withdrawn behavior
11. Refusal to speak

C. Cognitive (Thinking & Perception) Symptoms

1. Hallucinations (auditory, visual, olfactory, gustatory, & tactile)
2. Delusions
3. Suspiciousness
4. Disorganized thoughts (jumbled words)
5. Accelerated thoughts (racing thoughts)
6. Slowed or difficulty thinking
7. Inability to concentrate or stay focused
8. Confusion
9. Loss of memory
10. Diminished or no insight (inability to recognize their problem/illness)

II. Recognizing Characteristics of Mental Illness

Although police officers are not expected to identify or diagnose specific mental disorders, police

officers should be capable of identifying major behaviors or symptoms, which may be indicative of a mental illness. The function of diagnosing an individual with a specific mental illness should be left to a mental health professional. Although officers do need to determine that a mental illness may exist, so that he or she can decide the appropriate action. The purpose of following information is to provide officers with guidelines for identifying symptoms or behaviors, which may be indicative of a mental illness.

A. Cognitive symptoms of a serious mental illness represent internal perceptual or thinking states that are not readily observable from outward appearances, but are noticeable in conversation with the individual. Some of those symptoms may include, but are not limited to, one or more of the following:

1. Hallucinations - Some people with mental illnesses hear voices, see people/things, smell odors, taste things or feel things that are not there. The person experiences events that may have no apparent objective source, but that are nonetheless real to him or her. The most common hallucinations involve seeing or hearing things, but can involve any of the senses (hearing, vision, taste, smell or touch). A person may hear voices telling him or her to do something; see visions of God, the dead or horrible things; feel bugs/things crawling on his or her body; smell gas that they believe is being used to harm him or her; or taste poison in his or food.

2. Delusions - These are false beliefs that are not based on reality. They can cause a person to view the world from a unique or peculiar perspective. The individual will often focus on persecution (e.g., believe others are trying to harm him or her) or grandeur (person believes he or she is God, a saint, a famous person, or possesses a special talent or beauty).

3. Disorganized thoughts - Certain mental illnesses can cause a person's thoughts to be disorganized and jumbled. The speech content of such a person may be difficult to understand, making it difficult to determine what the person is trying to convey.

4. Accelerated thoughts - A person with mental illness may complain of "racing" thoughts, or their speech may be rapid, nonstop or pressured.

5. Confusion - Some people with mental illnesses may seem to be confused. They may be disoriented to time, place, person or situation.

6. Loss of memory - Temporary or permanent memory losses are clear symptoms of a mental/cognitive disturbance. This is not the normal forgetfulness that many people experience, but failure to remember the day, year, where one is, loved ones, their family, significant events, etc. The loss of memory is often associated with other cognitive/neurological disorders.

B. Mood or emotional symptoms of a serious mental illness may include internal emotional states that are not readily observable from outward appearances, but may be noticeable in conversation with the individual. Some of those symptoms may include, but are not limited to, one or more of the following:

1. Depression - Depression involves deep feelings of sadness, hopelessness or uselessness.

2. Anxiety - Anxiety may involve excessive worry, restlessness, tension, fright and/or

panic as well as physical symptoms such as trembling hands, dry mouth, sweaty palms or heart palpitations. Many people may describe their anxiety symptoms as "nervousness."

3. Elevated Mood - A person with an elevated mood may seem to be talkative, inappropriately happy, expansive or feeling "on top of the world."

4. Irritable Mood - A person may exhibit an irritable mood by being easily annoyed, angered, ill-tempered or hyper-sensitive to other people/situations.

5. Anger - Anger includes the feelings of extreme displeasure or rage toward someone or something.

C. In addition to the symptoms outlined above, some of the behaviors outlined below may be signs of a mental illness. However, some these behaviors can also be associated with cultural and personality differences, drug use or very stressful situations. As such, the presence of these behaviors should not be treated as conclusive proof of mental illness. They are provided only as a framework to aid police officers. Officers should obtain additional information at the scene from family, friends or health professionals who are familiar with the individual's behavior. Some of the behaviors commonly associated with mental illnesses are as follows:

1. Severe changes in behavioral patterns and attitudes - A normally quiet person may become suddenly very belligerent or over-talkative. A happy, outgoing person may become quiet and moody. While this may not be unusual, what is important is a change in general pattern of behavior extending over a period of time. You should ask family members and friends to determine the person's normal pattern of behavior.
2. Unusual/ bizarre behaviors or mannerisms.
3. Threatening, aggressive or hostile behavior.
4. Suicidal or self-injurious behavior.
5. Episodes of excessive spending.
6. Withdrawn behavior and/or refusal to speak.
7. Increase or decrease in normal level of activity.
8. Talking to themselves or one-sided conversations.

D. The degree to which these symptoms exist varies from person to person according to the type and severity of the mental illness. In some cases, the symptoms are pronounced, while they are less pronounced in other cases.

E. The officer responding to the scene is not expected to diagnose the specific mental illness, but is expected to recognize that these symptoms may indicate mental illness. This knowledge will help officers decide on an appropriate response and disposition.

III. Symptoms to be aware of from subjects in custody and the police response to persons in an excited state

In addition to effectively responding to encounters with people with mental illnesses, officers may encounter people in an excited state. This state may be due to any or all of the factors delineated formerly or may be induced by any of the conditions described to follow:

A. Cocaine-induced bizarre or frenzied behavior - When occurring while confined by

restraints, cocaine-induced excited delirium (an acute mental disorder characterized by impaired thinking, disorientation, visual hallucinations, illusions) may increase a subject's susceptibility to sudden death by effecting an increase of the heart rate to a critical level.

B. Drug and/or alcohol intoxication - Drug and acute alcohol intoxication is a major risk factor because respiratory drive is reduced. The subject so afflicted may not realize that suffocation is occurring.

C. Violent struggle extreme enough to require the officers to employ restraint techniques - Subjects who have engaged in extreme violent activities may be more vulnerable to subsequent respiratory muscle failure.

D. Unresponsiveness of subject during or immediately after a struggle - Such unresponsive behavior may indicate cardio-pulmonary arrest and the need for medical attention.

E. Excited Delirium - Excited delirium is regarded as a potentially lethal medical emergency in itself and may be part of the spectrum of manic-depressive psychosis, chronic schizophrenia and/or acute drug intoxication (cocaine, PCP, LSD, and amphetamines). It is described as an acute mental disorder characterized by impaired thinking, disorientation, visual hallucinations and illusions. Officers should be able to recognize the attendant symptoms, including any one of the following:

- Bizarre and/or aggressive behavior
- Self-inflicted injury
- Shouting
- Dilated pupils
- Paranoia
- Hallucinations
- Panic
- Undressing in public
- Violence towards others
- Hearing voices
- Unexpected physical strength
- Seizures
- Sudden tranquility
- High pulse rate
- Hyperthermia
- Thrashing after restraint
- Hiding behind bushes, trees or cars
- Yelling incoherently
- Feeling "bugs" on or under skin
- Prone to break glass
- Aggression towards objects
- Jumping into water

To help ensure safety and minimize the risk of sudden in-custody death, officers should be aware of these symptoms. When these symptoms are recognized, a medical unit shall be started to the location immediately. When possible, no contact should be made with the subject until the medical unit is on the scene. Subjects shall not be transported in the hog-tied prone position face down. As soon as the subject in secured get him off his stomach. Ask the subject if he has used drugs recently or suffers from any cardiac, respiratory disease or conditions such as asthma, bronchitis or emphysema (this information should be documented in the officers' narrative). Transportation of high risk subjects should be accomplished by two officers. The officer who is not driving shall monitor the suspect closely and continuously. Upon recognition of breathing difficulties or loss of consciousness, immediately transport the subject to a hospital emergency room.

Certain persons lying on their stomach have trouble breathing, a condition which can be intensified when pressure in applied to their back. The remedy seems to be simple; remove the pressure from the back. However, during a violent struggle between an officer(s) and subject(s), the solution may not be as simple.

Positional asphyxia can result when the abdomen is compressed to the extent that the ability to

expand the chest is impeded and insufficient oxygen amounts is drawn into the lungs. It can result in brain damage or death.

Abdominal compression can be caused by:

1. Weight, such as an officer sitting or kneeling on a subject.
2. Being wedged between objects.
3. The subject's own weight, and, possibly the subject's handcuffed arms.
4. Intrusions into the subject's abdomen, i.e., a vehicles drive shaft hump or the subject's potbelly.

Individuals who present an unusual high risk of sudden in-custody death include:

- Individuals suffering from mental illness or drug induced agitated delirium
- Obese people
- People with heart disease or respiratory problems

Guidelines to aid in preventing in-custody deaths

- Call for back-up
- Call for paramedic
- Transport subject in seated position or on his side
- Hog-tie as a last resort for officer safety
- Monitor closely

Resources

The Communications Unit shall retain the phone numbers for crisis assessment and referrals. The Mobile Mental Health Center Support services include 24-hour crisis management and awareness of community resources. The Center screens all calls for referral to appropriate levels of care and services within the Mental Health Center or to outside agencies.

Contact numbers for crisis intercession, assessment and referrals:

Mobile Mental Health Center	- Intake Coordinator	574-8699 or 450-2211
	- Nights and weekends	473-4423
Mobile County Sheriff's Department	- Lt. Lonnie Parsons	582-9857
	- Cpl. Joe Franklin	371-2773 or 689-6305 (cell)
	- Deputy David Vann	402-0110 (cell)

The Training Commander will stay informed of available community mental health resources for working knowledge and training purposes. The Training Section shall conduct refresher training courses on recognizing and handling persons with mental illness at least every three years. This training shall be documented

By order of:

Samuel M. Cochran
Chief of Police